THE U.S. DEPARTMENT OF DEFENSE PHARMACOECONOMIC CENTER

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Highlights of the Feb 2001 DoD P&T Executive Council Meeting and the DoD P&T Committee Meeting . . . 2 – 8

The key news from the 7 Feb 01 DoD Pharmacy & Therapeutics (P&T) Executive Council meeting was the addition of twelve drugs—clindamycin 150-mg capsules, amoxicillin/clavulanate, mupirocin ointment, single-dose fluconazole 150 mg, chlorhexidine gluconate 0.12% oral rinse, nitrofurantoin macrocrystals, loperamide capsules, lactulose syrup, metoprolol 50- and 100-mg, fluticasone oral inhaler, metoclopramide, and methotrexate—to the Basic Core Formulary (BCF). Issues discussed at the DoD P&T Committee meeting the following day included the National Mail Order Pharmacy (NMOP) Preferred Drug and Prior Authorization programs, the status of low molecular weight heparins in the NMOP,
and addition of six newly approved drugs to the NMOP Formulary.

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- DoD/VA returned goods contract awarded to Guaranteed Returns®
- Joint DoD/VA single-source contract for clotrimazole 1% topical cream awarded to Taro Pharmaceuticals

PDTS Corner: Update on the Pharmacy Data Transaction Service . . .9 – 11

DoD-wide implementation of the Pharmacy Data Transaction Service (PDTS) is proceeding rapidly, with 49 CHCS Host sites, the National Mail Order Pharmacy (NMOP), and three Managed Care Support Contractors (MCSCs) active as of mid-March 01. This issue's update includes links to the PDTS Customer Service Support Center (CSSC) documents on drug file validation and finding the reason for "NP" (not processed) prescriptions, a URL changes for the DEA database (it's now www.deanumber.com), an explanation of the differences between drug interaction definitions in CHCS and PDTS, and a succinct summary of the PDTS program.

In the News . . . 12 – 15

- **CDC Position Papers Tackle the Issue of Antibiotic Overuse for Acute Respiratory Tract Infections**
  In the 20 March 2001 issue of the Annals of Internal Medicine, a panel of physicians convened by the Centers for Disease Control and Prevention addresses the issue of antibiotic overuse in ambulatory care. The series of articles address appropriate antibiotic use for acute respiratory tract infections—acute sinusitis, acute pharyngitis, acute bronchitis, and nonspecific upper respiratory tract infections (including the common cold)—in immunocompetent adults without important comorbid diseases.
- **Patient Education Websites Regarding Inappropriate Antibiotic Use**
  Sources for handouts and other materials for patients that point out the consequences of inappropriate antibiotic use (and the futility of treating viral diseases with antibiotics...).
- **Depakote ER® - Easy to Confuse with Depakote® (Delayed Release)**
  A reprinted article from the Institute for Safe Medication Practices points out the potential for confusion with these two formulations of divalproex sodium, both of which are on the BCF.

Highlights of the February 2001 Meetings of the DoD Pharmacy & Therapeutics (P&T) Executive Council and the DoD Pharmacy & Therapeutics (P&T) Committee

DoD P&T Executive Council Meeting

MTF Requests for BCF Changes

Requests from MTFs for BCF changes at the Feb 01 meeting revolved around actions taken by the Council at the Nov 00 meeting. The Council considered requests to exclude methylphenidate extended-release (Concerta) from the BCF listing for methylphenidate, remove levofloxacin from the BCF and add gatifloxacin, and exclude divalproex sodium extended release (Depakote ER) from the listing for divalproex sodium. (BCF listings for oral medication normally include all formulations and strengths unless otherwise specified.)

Outline

DoD P&T Executive Council Meeting (7 Feb 2001)

- MTF Requests for BCF changes
- Basic Core Formulary Review
- Drugs Added to the BCF
- Pending Issues
- National Pharmaceutical Contracts
- Blanket Purchase Agreements

DoD P&T Committee Meeting (8 Feb 2001)

- NMOP Preferred Drug Program
- Prior Authorizations in the NMOP and Retail Network
- Low Molecular Weight Heparins
- Controlled Distribution of Dofetilide (Tikosyn), and Etanercept (Enbrel).
- New drugs added to the NMOP Formulary at this Meeting

Combined List: Changes to the Basic Core Formulary and National Mail Order Pharmacy (NMOP) Formulary

Minutes for the meetings are available on the PEC website at: **www.pec.ha.osd.mil/PT_Committee.htm**

- ***Methylphenidate extended-release tablets (Concerta)*** - The Council decided to let its Nov 00 decision not to exclude Concerta from the BCF listing for methylphenidate stand because 1) although it is true that Concerta has been compared only to immediate release methylphenidate, the longer duration of action (about 12 hours for Concerta, compared to 3-6 hours for methylphenidate immediate-release tablets and about 8 hours for the sustained release tablets) might give Concerta an advantage over other currently available methylphenidate products, and 2) although methylphenidate sustained release tablets should theoretically obviate the need for a midday dose, MTF prescription data show that midday doses are frequently prescribed for patients taking methylphenidate sustained release tablets. Analysis of a random sample of data from the Uniformed Services Prescription Database (USPD) for patients under the age of 18 who received more than one prescription for sustained-release methylphenidate during FY 00 showed that 60% (116/193) of patients received another medication for ADHD in addition to sustained-release methylphenidate and 40% of patients were prescribed a midday dose of either sustained-release methylphenidate or another medication for ADHD.

  The Council opted to include Concerta in the BCF listing for methylphenidate primarily because of the potential of the drug to obviate the need for midday doses and decrease the problems related to children receiving medication during the schoolday. It is too early to tell if patients receiving Concerta will require fewer noonday doses than patients receiving other ADHD medications. Future analysis of USPD data should cast some light on this question but will require data from patients who have received Concerta for a sufficient period of time for providers to assess its efficacy and to adjust therapy accordingly.

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[**Editor's note:** a new once-daily methylphenidate from Mallinkrodt (Metadate CD) is due to be launched in the very near future. Metadate CD is a once-daily methylphenidate formulation with an 8-hour half-life. In addition, a once-daily version of Adderall, tentatively trademarked Adderall XR, is in Phase III clinical trials. Results of the pivotal Phase III trial should be presented at the APA meeting in May 2001.]

- ***Request to remove levofloxacin (Levaquin) from the BCF and add gatifloxacin (Tequin) to the BCF*** – The Council did not change the BCF listing for levofloxacin, noting that its decision at the Nov 00 meeting to add levofloxacin to the BCF was based on similar safety, tolerability, and efficacy for the two drugs and pricing of $2.00 per daily dose through blanket purchase agreements for both levofloxacin and gatifloxacin. In addition, levofloxacin accounted for nearly 70% of all fluoroquinolone prescriptions dispensed at MTFs, while gatifloxacin accounted for less than 1% of fluoroquinolone prescriptions (as of Jan 01).

  The Council also discussed the revised BPA for levofloxacin, which offers levofloxacin 250 mg and 500 mg to all MTFs at an upfront price of $2.00 per tablet. This BPA makes it easier for MTFs to obtain levofloxacin at the BPA price, since MTFs are no longer responsible for individually monitoring drug usage to meet market share requirements. In addition, use of prescription data eliminates the problem of prime vendor purchases of ciprofloxacin being included in the denominator for calculating levofloxacin market share. Continuation of the BPA price is contingent upon levofloxacin achieving either (1) an 80% aggregate DoD market share within 6 months, or (2) a 50% market share at individual MTFs. Market share will be based on patient days of therapy and will be calculated from USPD prescription data.

  The Council was also informed that a new incentive price agreement offers gatifloxacin to MTFs at a price of $1.90 per daily dose. The incentive price is contingent on gatifloxacin having a "preferred or co-preferred formulary position" (effectively being on formulary in addition to levofloxacin) at an individual MTF.

- ***Divalproex sodium extended release (Depakote ER)*** - The Council agreed that while there is no data to prove better compliance with Depakote ER (dosed once daily) compared to Depakote (dosed twice daily), there was no compelling reason to depart from the general rule of including all oral dosage forms and strengths in the BCF listing for an oral drug. (Depakote ER is approved only for migraine prophylaxis.) The DoD P&T Council noted that it might specifically omit a dosage form or strength from the BCF if it is excessively expensive compared to the other dosage forms/strengths, or if impending availability of a generic equivalent makes it inadvisable to include a given dosage form. Depakote ER is priced essentially the same as Depakote on a per day basis.

  A Council member commented about the possibility of medication errors arising from confusion between Depakote 500 mg, which is a "delayed-release" formulation dosed twice daily, and Depakote ER 500 mg, an extended release formulation dosed once daily. The Council asked the PEC to call attention to the potential problem. See Page 15 for a reprinted article from the Institute for Safe Medication Practices (**www.ismp.org**).

As a reminder, requests for additions and/or deletions to the BCF can be initiated by any DoD healthcare provider (including MTF pharmacists) using the request form available on the Basic Core Formulary page of the PEC website (**www.pec.ha.osd.mil/ac01001.htm**). The form should be faxed or e-mailed to the DoD Pharmacoeconomic Center for consideration by the DoD P&T Committee.

Basic Core Formulary Review

At the Feb 01 meeting of the DoD P&T Executive Council, the PEC recommended a list of drugs for addition to the BCF based on information and analyses from a number of sources, including the Uniformed Services Prescription Database (USPD), a survey of MTF formulary status for various drugs, input from MTF providers, and drug usage and cost trends from prime vendor and USPD data. The primary impetus for adding additional medications to the BCF was the 1 Apr 01 expansion of the pharmacy benefit, which gives patients 65 and older

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access to the NMOP and the retail network to fill their prescriptions, in addition to the MTFs. Since prescriptions filled at MTF pharmacies ultimately cost DoD less than prescriptions filled at the NMOP or retail network pharmacies, a robust BCF is desirable to ensure that the majority of patients' needs can be consistently and uniformly met by MTF pharmacies.

However, the Council took a conservative approach to the addition of drugs to the BCF at the Feb 01 meeting because of the uncertain funding situation for the Defense Health Program in FY 01. Most of the 12 drugs added are already represented on a large percentage of MTF formularies.

How Drugs are Selected for the Basic Core Formulary

The objective of the Basic Core Formulary is to ensure uniform availability of cost-effective pharmaceuticals at MTF pharmacies to meet the majority of patients' primary care needs. Drugs are selected for the BCF by comparing drugs to other agents in the class or other agents that are used for a given disease/condition, based on the following factors:

Safety

Tolerability

Efficacy / Effectiveness

Price / Cost

Other factors, including but not limited to:

- Place in therapy / clinical niche
- Interchangeability of drugs in the class
- Variability in patient response to drugs in the class
- MTF provider opinions / preferences
- Market share trends within the drug class
- Percentage of MTFs that have the drug on formulary
- Potential for inappropriate use
- Patent expirations and impending availability of generic equivalents

Drugs Added to the BCF

Drugs added to the BCF included a number of anti-infective agents, including two oral antibacterials: **clindamycin 150-mg capsules** (as an alternative in penicillin-allergic patients and for treatment of polymicrobial infections where anaerobes are suspected) and **amoxicillin/clavulanate (Augmentin) tablets and suspension** (widely used to treat respiratory tract infections and otitis media where a penicillinase-producing organism is known or suspected). Although the BCF has included only a few antibiotics in the past, usage of these agents is widespread and not highly specialized. **Mupirocin ointment**, a topical antibacterial agent, was added largely due to its utility in the treament of impetigo and its lower side effects compared to oral antibiotic therapy. The **single dose regimen of fluconazole oral for vaginal candidiasis (150-mg)** was added because of its advantage of single-dose therapy, ease of administration, and equal efficacy to topical creams. **Chlorhexidine gluconate 0.12% oral rinse** was added for gingivitis.

Nitrofurantoin macrocrystals (generic equivalents to Macrodantin) were added for the treatment and suppression of UTI. Nitrofurantoin is recommended as one of the primary agents in the DOD Acute Dysuria or Urgency in Women Guideline. **The listing for nitrofurantoin does not include Macrobid®**, which the committee agreed offers no significant clinical advantage over available generic products. The **prescription formulation of the antidiarrheal agent loperamide (2-mg capsules)** was added as a safer, non-controlled alternative to diphenoxylate/atropine as an antidiarrheal agent. **Lactulose syrup** was added mainly because of its utility in childhood constipation.

Metoprolol 50- and 100-mg were added to the BCF, which did not previously include a beta-blocker. Metoprolol has proven mortality benefits in hypertension, angina, post-MI, and in selected CHF patients (stable NYHA II and NYHA III). **The BCF listing for metoprolol 50-100 mg does not include Toprol XL®**, which was excluded because there are insufficient clinical advantages to justify the incremental cost compared to immediate release metoprolol.

The Council added **fluticasone oral inhaler (Flovent)**, to the BCF primarily because of the

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How well does the BCF meet the majority of patients' primary care needs?

An analysis of USPD data showed that **72.6%** of the prescriptions filled at MTF pharmacies in FY 00 were filled with drugs that were on the BCF as of Sep 00. Prescriptions for most over-the-counter drugs were excluded from the analysis because they generally are not eligible for inclusion on the BCF.

This is a conservative estimate, since the analysis did not characterize second-generation antihistamines, low molecular weight heparins, leukotriene antagonists, and estrogenic vaginal creams as BCF drugs, even though the BCF requires MTFs to have at least one agent from each of those drug classes on the MTF formulary.

availability of a high potency formulation. Of the two high potency inhaled corticosteroids (ICS), fluticasone has a significant share of the market compared to budesonide (39% versus 3.5%), based on prime vendor purchases through Sep 00. Fluticasone and budesonide were not considered by the committee to be therapeutically interchangeable primarily because of the difference in dosage form. Budesonide is a dry powder inhaler (DPI); fluticasone is available as both a metered dose inhaler (MDI) and a DPI. Significant and costly patient education would be required to switch patients currently on fluticasone to budesonide. In addition, fluticasone may be more desirable than budesonide because of reported difficulty administering the correct dose due to the lack of tactile feedback and because breath actuation with budesonide may be particularly difficult for children.

Pricing in the oral corticosteroid class has increased significantly over the last six months. DAPA prices for orally inhaled corticosteroids have increased an average of 30.7% since Sep 00, with price increases ranging from 1.5% to 127% (for Vanceril® 42 mcg/inhalation).

The last two drugs added to the BCF were **methotrexate** and **metoclopramide**. Although there was some debate about the primary care nature of methotrexate, the committee agreed that, while likely initiated by a specialist, ongoing prescriptions for methotrexate are likely to be written and patients monitored by primary care providers.

The Council considered clinical information and usage data regarding gabapentin, COX-2 inhibitors, and long-acting dihydropyridine calcium channel blockers, but did not add any of these drugs to the BCF.

Pending Issues

The PEC is reviewing **topical corticosteroids, benzodiazepines, and medications for acne and overactive bladder**. Information on these drugs will be presented at the next meeting of the P&T Executive Council. A question concerning whether **lancets** should be added to the BCF arose during the meeting and was tabled until the next meeting. A blood glucose test strip (Precision QID) is listed on the BCF.

National Pharmaceutical Contracts

New contracts reported at the meeting: Two new contracts were reported: a joint VA/DoD single-source contract for clotrimazole 1% topical cream, awarded to Taro Pharmaceuticals with an effective date of 1 Feb 01, and the joint VA/DoD returned goods contract, awarded on 21 Jan 01 to Guaranteed Returns. See the Contract Update on Page 14 for more information.

Contracts in development: A total of 32 joint VA/DoD national contracts have been awarded, and approximately 25 more contracts are in various stages of development (primarily joint VA/DoD mandatory source contracts). Information on national pharmaceutical contracts is available on the DSCP website (**www.dmmonline.com**).

Contracts in Progress

- *Joint VA/DoD contract for non-sedating antihistamines* – The General Accounting Office (GAO) recently denied the only remaining protest of the solicitation for a joint VA/DoD "closed class" contract for a non-sedating antihistamine. The GAO denial of the last, pre-award protest opens the way for a contract to be awarded by the VA National Acquisition Center (NAC).
- *Joint VA/DoD contract for oral contraceptive contracts* – DSCP is working on joint VA/DoD

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mandatory source contracts for four oral contraceptive products: 35 mcg ethinyl estradiol (EE) / 1 mg norethindrone; 35 mcg EE / 1 mg ethynodiol diacetate; 30/40/30 mcg EE / 0.05/0.075/0.125 mcg levonorgestrel; and 0.35 mg norethindrone.

Potential contracts – DoD and VA officials will evaluate the potential for soliciting for a joint VA/DoD closed class contract for a high potency aqueous nasal corticosteroid inhaler after the VA has finished its clinical review of the drug class. The Council discussed the suitability of the low molecular weight heparin drug class for a contracting initiative, but came to no definitive conclusion. The PEC is collecting additional information, including input from MTF providers, to help the Council determine suitability of drugs in this class for contracting.

Financial impact of contracts – The final estimate of MTF cost avoidance due to national pharmaceutical contracts was $65.2 million in FY 00, which equals 6.3% of the $1.03 billion that MTFs spent on pharmaceuticals. The weighted average percent reduction in cost for the drugs and drug classes affected by national pharmaceutical contracts was 25.3%. See Appendix A of the Feb 01 DoD P&T Executive Council minutes for a summary of cost avoidance from national pharmaceutical contracts.

Blanket Purchase Agreements

The Council agreed that it should be more involved in the process of establishing BPAs in order to ensure that the provisions of a BPA support the Council's strategy for managing a given drug class. The Council also advocated the development of a more clearly defined process for establishing joint VA/DoD BPAs. A subcommittee is currently working on these issues.

Update on Leutinizing hormone releasing hormone (LHRH) agonists – A BPA makes goserelin (Zoladex) available to MTFs at the VA national contract price in exchange for attainment of an 80% overall share of the MTF prescriptions for LHRH agonists for prostate cancer. At the Nov 00 meeting, the Council asked DSCP and the PEC to initiate an education/marketing campaign to ensure that goserelin achieves the market share required by the BPA. Since the Nov 00 meeting, information regarding the Council's decision and the BPA was published in the P&T Executive Council minutes and in the Dec 00 PEC Update; urology specialty leaders were notified of the BPA and information forwarded to urologists; and information about the goserelin BPA was provided to the pharmacy and/or urology departments at MTFs with high leuprolide usage.

The Council reviewed MTF prescription data for LHRH agonists, but concluded that it was too early to tell whether MTFs are on track to achieve the 80% market share for goserelin by 1 Aug 01. The Council was informed that DSCP recently accepted a BPA from TAP Pharmaceuticals that lowers the price of leuprolide, but still leaves leuprolide with a higher price per dose than goserelin. The Council concluded that the goserelin BPA offers the best value for the MHS and reaffirmed its desire to have goserelin reach an 80% market share by 1 Aug 01.

DoD P&T Committee Meeting

Non-Preferred/Preferred Drug Pairs In The NMOP

- As a rule, the NMOP Formulary includes all FDA-approved non-injectable medications unless specifically excluded by the DoD P&T Committee or, in the case of new drugs, awaiting review by the committee. It also contains a short list of non-preferred drugs and preferred alternatives established by the DoD P&T Committee. Under the NMOP Preferred Drug program, pharmacists from the NMOP contractor, Merck-Medco, call providers requesting changes from non-preferred agents to preferred alternatives. Cost avoidance from the program amounted to $1.8 million in FY 00, or $101 per attempted provider contact.

Prior Authorizations in the NMOP and Retail Network

- ***Proposal to change the COX-2 inhibitor PA to reflect findings of the Celecoxib Long-term Arthritis Safety Study (CLASS)*** – Results of the CLASS study suggest that even low doses of aspirin may reduce or eliminate the GI protective effect of COX-2 selective NSAIDs compared to conventional NSAIDS, since the annualized incidence rates of upper GI ulcer

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complications/symptomatic ulcers were not significantly different for celecoxib versus NSAIDS for patients in the CLASS study who were also receiving low dose aspirin. The data, however, were limited: the number of patient-years of therapy for patients receiving low dose aspirin was relatively low, results were based on a maximum of 6 months of therapy, and the dropout rates in both the celecoxib and NSAID group were high (40-45%). The Committee agreed that there are insufficient data to change the PA criteria to preclude usage of COX-2 inhibitors by patients taking low dose aspirin, but requested that the PEC revise the clinical rationale language on the PA forms to include information on the results of the CLASS study in regard to the use of COX-2 inhibitors in patients currently receiving low dose aspirin.

- ***Prior authorization of ciclopirox topical solution (Penlac Nail Lacquer) in the NMOP and retail network*** –Since other drugs for onychomycosis require prior authorization in the NMOP and retail network to ensure that they are used only when clinically appropriate (when a fungal infection is present), the Committee agreed that the same standard should be applied to ciclopirox. The committee voted to institute a PA for ciclopirox topical solution that requires confirmation of a fungal infection.

Status of Low Molecular Weight Heparins (LMWHs) in the NMOP

The Committee discussed the potential need to have LMWHs available through the NMOP. The PEC is assessing the opinions of providers about the necessity to have the LMWHs available through the NMOP.

Controlled Distribution of Dofetilide (Tikosyn) and Etanercept (Enbrel)

Dofetilide - Because of specialized educational requirements mandated by the FDA, dofetilide is only available for outpatient use through Stadtlander's Pharmacy/CVS Procare (which is a non-network pharmacy for DoD beneficiaries). COL Davies reported that the 50% copay penalty for using a non-network pharmacy can be waived retroactively, but the process is cumbersome. Attempts to establish a central funding process for dofetilide have thus far been unsuccessful.

Etanercept - Although a plan to supply etanercept only through the NMOP had been contemplated, etanercept would continue to be available through MTF pharmacies, retail network pharmacies, and the NMOP. Immunex and Wyeth Ayerst have allotted supplies to MTF pharmacies based on historical usage data, so MTF pharmacies (unlike retail pharmacies) are not required to submit patient enrollment numbers to obtain etanercept. DoD beneficiaries can therefore obtain etanercept from MTF pharmacies even if they did not enroll with Immunex. However, unenrolled patients may experience problems if they need to obtain etanercept from a retail pharmacy.

[**Editor's Note:** A procedure to deal with the situation of DoD patients who are not enrolled with Immunex obtaining etanercept from retail pharmacies rather than MTFs (e.g., secondary to PCS moves or separation), is being worked out with Immunex/Wyeth-Ayerst and will be sent to MTF pharmacists as soon as it is completed.]

Newly Approved Drugs Added to the NMOP Formulary

New drugs added to the NMOP Formulary at this meeting were:

- Abacavir / lamivudine / zidovudine (Trizivir; Glaxo)
- Balsalazide disodium (Colazal; Salix)
- Nateglinide tablets (Starlix; Novartis)
- Sodium phosphate, dibasic, anhydrous / sodium phosphate monobasic, monohydrate (Visicol; Inkine)
- Telmisartan/HCTZ (Micardis HCT; Boehringer-Ingelheim)
- Tacrolimus ointment (Protopic; Fujisawa)

Please see Appendix A in the Feb 01 DoD P&T Committee minutes for more information. None of these drugs were added to the BCF.

Summary of Changes to the Basic Core Formulary and National Mail Order Pharmacy Formulary

Resulting from the February 2001 meetings of the DoD Pharmacy and Therapeutics Executive Council and the DoD Pharmacy and Therapeutics Committee

1. BCF Changes

A. *Additions to the BCF* (See the 7 Feb 01 P&T Executive Council Minutes, Paragraph 10B & Appendix C)

1) Clindamycin 150-mg capsules
2) Loperamide 2-mg capsules
3) Chlorhexidine gluconate 0.12% oral rinse (e.g., Peridex®, Periogard®, generics)
4) Amoxicillin/clavulanic acid oral (tablets and suspension)
5) Fluconazole oral, 150-mg tablets only. Includes only the single-dose regimen for treatment of vaginal candidiasis.
6) Metoclopramide oral
7) Mupirocin ointment
8) Metoprolol 50- and 100-mg oral. Does not include Toprol XL.
9) Fluticasone oral inhaler
10) Lactulose syrup
11) Methotrexate oral
12) Nitrofurantoin macrocrystals (generic equivalents to Macrodantin). Does not include Macrobid.

B. *Changes and clarifications to the BCF* - None

2. NMOP Formulary Changes

A. *Additions to the NMOP Formulary* (See the 8 Feb 01 DoD P&T Committee Meeting minutes, Appendix A)

1) Abacavir / lamivudine / zidovudine (Trizivir; Glaxo)
2) Sodium phosphate, dibasic, anhydrous / sodium phosphate monobasic, monohydrate (Visicol; Inkine)
3) Balsalazide disodium (Colazal; Salix)
4) Telmisartan/HCTZ (Micardis HCT; Boehringer-Ingelheim)
5) Tacrolimus ointment (Protopic; Fujisawa)
6) Nateglinide (Starlix; Novartis)

B. *Exclusions from the NMOP Formulary* – None

C. *Changes to the NMOP Preferred Drug Program* (See the 8 Feb 01 DoD P&T Committee Meeting minutes, Appendix B)

1) Procardia XL will be removed from the list of non-preferred drugs when generic equivalents are available for all strengths of Procardia XL.
2) Vasotec was removed from the list of non-preferred drugs when a generic equivalent became available at a competitive price in Dec 00.

3. Quantity Limit Changes (NMOP and retail network) – none

4. Changes to the Prior Authorization Program (NMOP and Retail Network)

A. A prior authorization that requires diagnostic verification of a fungal infection will be instituted for ciclopirox topical solution (Penlac Nail Lacquer) (See the 8 Feb 01 DoD P&T Committee Meeting minutes, Paragraph 8F).

Contract Update

Returned Goods Contract Awarded to Guaranteed Returns®

On January 30, 2001, Defense Supply Center Philadelphia (DSCP) awarded a joint contracting initiative between the Department of Defense (DoD) and Department of Veteran Affairs (DVA) for a complete Pharmaceutical Returns Management Program to Guaranteed Returns. Guaranteed Returns will be the preferred supplier to provide DoD and VA medical facilities in the United States (includes Puerto Rico and Guam), overseas U.S. military bases (Europe and Pacific Rim), and VA facilities in the Philippines with a returned goods program that is compliant with all contract requirements, laws, and regulations. (Returns from overseas customers will not include Schedule II-V controlled substances.)

The contract will run for an initial 15-month period with three 15-month option periods. Benefits of the contract include: lump-sum crediting directly through the prime vendor/wholesaler for all creditable full and partial pharmaceutical returns; credit tracking and reconciliation; service fee billed through the Prime Vendor/Wholesaler and based on actual credit issued; and reduced disposal fees. More information on the program, including a form for online enrollment and a copy of the contract, is available on the DSCP website (**www.dmmonline.com**).

New Contracts

- Joint VA/DoD single-source contract for clotrimazole 1% topical cream, awarded to Taro Pharmaceuticals with an effective date of 1 Feb 01

For More Information

Visit DSCP's DMMOnline website (**www.dmmonline.com**) or go straight to the contract page at **http://dscp305.dscp.dla.mil/dmmonline/pharm/contracts.asp.**

PDTS Corner: Update on the Pharmacy Data Transaction Service

PDTS Implementation Proceeding Rapidly

Sonya Edom, Customer Service Supervisor at the PDTS Customer Service Support Center (CSSC), reports that:

- Total transactions for the month of Feb: 2,592,406. Of these, 92% were PAID (active prescriptions), 6% were reversed, and 2% were rejected.
- The highest number of transactions in a single day was 167,199 total transactions. An average of 145,761 transactions were processed from 26 Feb - 2 Mar 01.
- As of mid-March 01, 49 CHCS Host sites are active, as are 3 Managed Care Support Contractors (MCSCs), and the National Mail Order Pharmacy (NMOP). The three MCSCs already active are Tri-West (Regions 7 and 8), Humana (Regions 3 and 4), and Foundation (Regions 6,9,10 and 11). Sierra (Region 1) and Anthem (Regions 2 and 5) will be active before 1 April 2001.
- Over 650 potential Level 1 Drug Interactions (see definitions below) have been identified so far in FY01.
- The average transaction time is between 3 and 4 seconds (from the time the user files the prescription until they receive a response from PDTS).

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PDTS Corner: Update on the Pharmacy Data Transaction Service

Differences between Drug Interaction Definitions in CHCS and PDTS

While both definitions are based on and utilize First Data Bank as a reference source, PDTS uses the newer version of DDIM 3.2 and CHCS uses DDIM 3.0. (Today, the industry standards are 3.1 or 3.2. The 3.0 version is no longer supported for the commercial environment and 3.1 will soon be phased out.) As a result, the definitions of a Level 1, 2 and 3 drug interaction as reported by PDTS are different than CHCS.

When PDTS checks for drug-drug interactions it only looks at "PAID" claims that are on the patient profile for the past 180 days. It does not take into account the length of therapy when reporting these interactions back to the provider or pharmacist. As always, it is important that the provider or pharmacist interact with the patient to determine if the reported drug conflict is valid.

PDTS Definitions (DDIM 3.2)	CHCS Definitions (DDIM 3.0)
Level 1 - Contraindicated Drug Combination This drug combination is clearly contraindicated in all cases and should not be dispensed or administered to the same patient.	**Level 1 - Severe Interaction** Action is required to reduce risk of severe adverse interaction
Level 2 - Severe Interaction Action is required to reduce risk of severe adverse interaction	**Level 2 - Moderate Interaction** Assess risk to patient and take action as needed
Level 3 - Moderate Interaction Assess risk to patient and take action as needed	**Level 3 - Possibly Most Significant** Conservative measures are recommended because the potential for severe adverse consequences exists

Contacting the PDTS Customer Support Center

Call 1-800-600-9332, DSN 240-4150, or (210) 536-4150, and select Option 1.

URL change for the DEA database

The URL for the DEA website has changed to **www.deanumber.com**.

CSSC Documents Available on the PEC Website in MS Word Format:

- Drug File Validation:
- Where to find the reason for a "NP" (not processed) Prescription:
- Lessons Learned from PDTS Activations (Updated March 01)

Visit: www.pec.ha.osd.mil/Updates/0103web/Mar_01_Update_Page_5.htm

For More Information about PDTS

- Visit the Pharmacy Data Transaction Service Page (**www.tricare.osd.mil/pharmacy/data_trans.htm**) on the TRICARE Pharmacy Site (**www.tricare.osd.mil/pharmacy/**).
- Or see back issues of the PEC Update (**www.pec.ha.osd.mil/ac03000.htm**):

  Jan 2001: Latest news, "Lessons Learned" from MTF activations of PDTS

  December 2000: Accessing the TMSSC InfoNet site

  October 2000: More info on PDTS, PDTS trifold brochure for providers, change of access numbers and hours of operation for the CSSC, provider validation Ad Hoc report

  January 2000: The PDTS Customer Service Support Center

PDTS Corner: Update on the Pharmacy Data Transaction Service

What is PDTS?

- The Pharmacy Data Transaction Service (PDTS) provides a central data repository for prescriptions filled by DoD beneficiaries throughout the Military Health System (MHS), including the direct care system (MTFs), the Managed Care Support Contractor (MCSC) retail pharmacy network, and the National Mail Order Pharmacy (NMOP).

- PDTS makes possible interactive clinical screening of a complete patient profile for drug interactions, therapeutic overlaps, and duplicate therapies, regardless of where prescriptions are filled. PDTS also provides a robust data repository for detailed and aggregate management and clinical reporting.

Critical factors for the success of PDTS

- A secure, reliable communication infrastructure for real time transactions
- Round trip transmission < 6 secs
- Encrypted transactions
- Data integrity
- Unique identifiers for providers, patients, and medications
- Standardized business practices

The PDTS Customer Service Support Center

- To support PDTS and its customers, DoD directed the Pharmacoeconomic Center to establish a PDTS support office. Day-to-day operations of this new element of the PEC, the PDTS Customer Service Support Center, is currently managed by the Tri-Service Medical Systems Support Center (TMSSC), located at Brooks AFB in San Antonio, TX.

The PDTS Customer Service Support Center (CSSC) offers help-desk, technical, and functional support on PDTS transmission issues. The staff of the CSSC includes 2 pharmacists, 1 nurse, 13 pharmacy technicians, 1 logistician, and 2 customer service coordinators. It is organized into two tiers:

Tier 1 - Customer Service Coordinators
- Primary POC for customers
- Handle non-clinical issues
- Monitor MCSC/NMOP for non-matching NDC#s
- Monitor MTF rejections
- Research DEA and NDC numbers

Tier II - Clinical Support Coordinators
- POC for clinical issues
- Monitor compliance with:
  - Closed class utilization
  - Mandatory source contract purchases
  - Maximum days supply/quantity limits
- Develop PDTS Ad Hoc reports
- Obtain National Council for Prescription Drug Programs (NCPDP) numbers for MTFs

- Depending on the type of problem, resolution can be expected within minutes of calling the CSSC. If a problem must be escalated to a higher level, the CSSC staff will coordinate/monitor problem resolution. The CSSC goal is a 98% resolution rate on initial calls.

Potential Trouble Areas/Types of Edits

- *Administrative Edits*
  Referred to as hard edits or reject messages, they can result when any one of the following are missing or incorrect in a transmission. Users cannot override administrative edits, must fix and re-transmit.
  - A unique dispensing location number
  - A unique provider identification number
  - A unique patient identification number
  - A unique national drug code

- *ProDUR Edits*
  Referred to as soft edits or advisory messages, they can result when there is the potential for any of the following to occur. Users may override ProDUR edits. NOTE: ProDUR edits may or may not be turned on
  - Drug to drug interactions
  - Therapeutic duplications and/or too early refill
  - Excessive or insufficient dose
  - Over or under utilization

- *Miscellaneous Edits*
  - Max days supply/excessive quantity exceeded - results in a reject message, may override and re-transmit
  - Mandatory source policy - results in a reject message, may override and re-transmit.

When to call the PDTS CSSC

- For assistance correcting a reject message
- For specific information on a ProDUR edit
- For assistance researching DEA or NDC #s
- If you need a PDTS Ad Hoc report
- For questions relating to PDTS

PDTS CSSC: 1-800-600-9332, DSN 240-4150, or (210) 536-4150, and select Option 1

In the News

- **CDC Position Papers Tackle the Issue of Antibiotic Overuse for Acute Respiratory Tract Infections**
- **Patient Education Websites Regarding Inappropriate Antibiotic Use**
- **Depakote ER® - Easy to Confuse with Depakote® (delayed release)**

CDC Position Papers Tackle the Issue of Antibiotic Overuse for Acute Respiratory Tract Infections

In the 20 March 2001 issue of the Annals of Internal Medicine **(www.annals.org)**, a panel of physicians convened by the Centers for Disease Control and Prevention (**www.cdc.gov**) takes on the task of addressing the issue of antibiotic overuse in ambulatory care. The series of articles address appropriate antibiotic use for acute respiratory tract infections—acute sinusitis, acute pharyngitis, acute bronchitis, and nonspecific upper respiratory tract infections (including the common cold)—in immunocompetent adults without important comorbid diseases. The following information is excerpted (by permission) from the position papers. In addition to the CDC, the principles outlined in this series have been endorsed by the American Academy of Family Physicians, the American College of Physicians-American Society of Internal Medicine, and the Infectious Diseases Society of America.

Principles of Appropriate Antibiotic Use for Treatment of Acute Respiratory Tract Infections in Adults: Background, Specific Aims, and Methods (Gonzales R, Bartlett J, Besser R, et al. Ann Intern Med 2001;134:479-86.)

The need to decrease excess antibiotic use in ambulatory practice has been fueled by the epidemic increase in antibiotic-resistant *Streptococcus pneumoniae*. The majority of antibiotics prescribed to adults in ambulatory practice in the United States are for acute sinusitis, acute pharyngitis, acute bronchitis, and nonspecific upper respiratory tract infections (including the common cold). For each of these conditions—especially colds, nonspecific upper respiratory tract infections, and acute bronchitis (for which routine antibiotic treatment is not recommended)— a large proportion of the antibiotics prescribed are unlikely to provide clinical benefit to patients. Because decreasing community use of antibiotics is an important strategy for combating the increase in community-acquired antibiotic-resistant infections, the Centers for Disease Control and Prevention convened a panel of physicians representing the disciplines of internal medicine, family medicine, emergency medicine, and infectious diseases to develop a series of "Principles of Appropriate Antibiotic Use for Treatment of Acute Respiratory Tract Infections in Adults." These principles provide evidence-based recommendations for evaluation and treatment of adults with acute respiratory illnesses.

The Need To Improve Antibiotic Prescription for Acute Respiratory Infections

1. **The epidemic increase in antibiotic-resistant *Streptococcus pneumoniae* is an ambulatory care problem.**
2. **Previous antibiotic use is an important risk factor for carriage of and infection with antibiotic-resistant *Streptococcus pneumoniae*.**
3. **Most antibiotic prescriptions in the ambulatory setting are for acute respiratory infections.**

The Web site on antimicrobial resistance of the CDC Respiratory Diseases Branch (**www.cdc.gov/ncidod/dbmd/antibioticresistance/**) will be used to provide updates and obtain feedback from clinicians.

Principles of Appropriate Antibiotic Use for Treatment of Nonspecific Upper Respiratory Tract Infections in Adults: Background (Gonzales R, Bartlett J, Besser R, et al. Ann Intern Med 2001;134:490-4.)

1. The diagnosis of nonspecific upper respiratory tract infection or acute rhinopharyngitis should be used to denote an acute infection that is typically viral in origin and in which sinus, pharyngeal, and lower airway symptoms,

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although frequently present, are not prominent.

2. Antibiotic treatment of adults with nonspecific upper respiratory tract infection does not enhance illness resolution and is not recommended. Studies specifically testing the impact of antibiotic treatment on complications of nonspecific upper respiratory tract infections have not been performed in adults. Life-threatening complications of upper respiratory tract infection are rare.
3. Purulent secretions from the nares or throat (commonly observed in patients with uncomplicated upper respiratory tract infection) predict neither bacterial infection nor benefit from antibiotic treatment.

Principles of Appropriate Antibiotic Use for Acute Rhinosinusitis in Adults: Background

(Hickner J, Bartlett J, Besser R, et al. Ann Intern Med 2001;134:498-505.)

1. Most cases of acute rhinosinusitis diagnosed in ambulatory care are caused by uncomplicated viral upper respiratory tract infections.
2. Bacterial and viral rhinosinusitis are difficult to differentiate on clinical grounds. The clinical diagnosis of acute bacterial rhinosinusitis should be reserved for patients with rhinosinusitis symptoms lasting 7 days or more who have maxillary pain or tenderness in the face or teeth (especially when unilateral) and purulent nasal secretions. Patients with rhinosinusitis symptoms that last less than 7 days are unlikely to have bacterial infection, although rarely some patients with acute bacterial rhinosinusitis present with dramatic symptoms of severe unilateral maxillary pain, swelling, and fever.
3. Sinus radiography is not recommended for diagnosis in routine cases.
4. Acute rhinosinusitis resolves without antibiotic treatment in most cases. Symptomatic treatment and reassurance is the preferred initial management strategy for patients with mild symptoms. Antibiotic therapy should be reserved for patients with moderately severe symptoms who meet the criteria for the clinical diagnosis of acute bacterial rhinosinusitis and for those with severe rhinosinusitis symptoms—especially those with unilateral facial pain—regardless of duration of illness. For initial treatment, the most narrow-spectrum agent active against the likely pathogens, *Streptococcus pneumoniae* and *Haemophilus influenzae*, should be used.

Recommended Guideline for Discussing the Management of Acute Bronchitis with Patients

1. Provide realistic expectations for the duration of the patient's cough, which will typically last 10 to 14 days after the office visit.
2. Refer to the cough illness as a "chest cold" rather than bronchitis.* In a study of members of a commercial managed care organization's health plan, use of the term "chest cold" was associated with much less frequent belief that antibiotic therapy was necessary to get better.
3. Personalize the risk of unnecessary antibiotic use. Inform patients that previous antibiotic use increases their likelihood of carriage of and infection with antibiotic-resistant bacteria, that antibiotics commonly have side effects (gastrointestinal symptoms or alterations in taste, for example), and that rare but serious adverse reactions may occur, such as anaphylaxis.
4. Explain to patients why we need to be more selective in treating only those conditions for which a major clinical benefit of antibiotics has been proven—tell them that the current epidemic in antibiotic resistance among community bacterial pathogens is a major public health concern.

*Gonzales R, Wilson A, Crane LA, Barrett PH Jr. What's in a name? Public knowledge, attitudes, and experiences with antibiotic use for acute bronchitis. Am J Med. 2000;108:83-5.

Principles of Appropriate Antibiotic Use for Acute Pharyngitis in Adults: Background

(Cooper R, Hoffman J, Bartlett J, et al. Ann Intern Med 2001;134:509-17.)

1. Group A ß-hemolytic streptococcus (GABHS) is the causal agent in approximately 10% of adult cases of pharyngitis. The large majority of adults with acute pharyngitis have a self-limited illness, for which supportive care only is needed.
2. Antibiotic treatment of adult pharyngitis benefits only those patients with GABHS infection. All patients with pharyngitis should be offered appropriate doses of analgesics and antipyretics, as well as other supportive care.
3. Limit antibiotic prescriptions to patients who are most likely to have GABHS infection. Clinically screen all adult patients with pharyngitis for the presence of the four Centor criteria: history of fever, tonsillar exudates, no cough, and tender

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anterior cervical lymphadenopathy (lymphadenitis). Do not test or treat patients with none or only one of these criteria, since these patients are unlikely to have GABHS infection. For patients with two or more criteria the following strategies are appropriate: a) test patients with two, three, or four criteria by using a rapid antigen test, and limit antibiotic therapy to patients with positive test results; b) test patients with two or three criteria by using a rapid antigen test, and limit antibiotic therapy to patients with positive test results or patients with four criteria; or c) do not use any diagnostic tests, and limit antibiotic therapy to patients with three or four criteria.

4. Throat cultures are not recommended for the routine primary evaluation of adults with pharyngitis or for confirmation of negative results on rapid antigen tests when the test sensitivity exceeds 80%. Throat cultures may be indicated as part of investigations of outbreaks of GABHS disease, for monitoring the development and spread of antibiotic resistance, or when such pathogens as gonococcus are being considered.
5. The preferred antibiotic for treatment of acute GABHS pharyngitis is penicillin, or erythromycin in a penicillin-allergic patient.

Principles of Appropriate Antibiotic Use for Treatment of Uncomplicated Acute Bronchitis: Background (Gonzales R, Bartlett J, Besser R, et al. Ann Intern Med 2001;134:521-9.)

1. The evaluation of adults with an acute cough illness or a presumptive diagnosis of uncomplicated acute bronchitis should focus on ruling out serious illness, particularly pneumonia. In healthy, nonelderly adults, pneumonia is uncommon in the absence of vital sign abnormalities or asymmetrical lung sounds, and chest radiography is usually not indicated. In patients with cough lasting 3 weeks or longer, chest radiography may be warranted in the absence of other known causes.
2. Routine antibiotic treatment of uncomplicated acute bronchitis is not recommended, regardless of duration of cough. If pertussis infection is suspected (an unusual circumstance), a diagnostic test should be performed and antimicrobial therapy initiated.
3. Patient satisfaction with care for acute bronchitis depends most on physician-patient communication rather than on antibiotic treatment.

Patient Education Websites Regarding Inappropriate Antibiotic Use

The CDC has a dedicated area on its website specifically for patient education about the consequences of inappropriate antibiotic use. Handouts can be downloaded from the following address: **www.cdc.gov/drugresistance/technical/prevention_tools.htm.** The site includes a child-care provider letter and prescription pad to explain to parents that antibiotics are often not necessary or useful. There are also academic detail sheets discussing pharyngitis, cough and bronchitis, sinusitis, otitis media, rhinitis, resistance due to antibiotic overuse and practice tips. A slide set entitled “Judicious Use of Antibiotics” is also available.

Other Useful Sites

- Wisconsin Antibiotic Resistance Network (WARN): **www.wismed.org/warn/home.htm**
- Alliance for the Prudent Use of Antibiotics (APUA):**www.healthsci.tufts.edu/apua/apua.html**

Depakote ER® - Easy to Confuse with Depakote® (delayed release)

At the Feb 01 meeting, the DoD P&T Executive Council requested that the PEC call attention to the potential problem of medication errors arising from confusion between Depakote 500 mg, a "delayed-release" formulation dosed twice daily, and Depakote ER 500 mg, an extended release formulation dosed once daily. The following article is reprinted with permission from the Institute for Safe Medication Practices (ISMP), a non-profit organization dedicated to educating the healthcare community about safe medication practices. (Visit them on the Web at **www.ismp.org**.)

PROBLEM

Abbott recently marketed DEPAKOTE **ER®**, a new tablet formulation of extended release divalproex sodium intended for migraine sufferers. This product

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has a polymer matrix delivery system that sustains the release of divalproex sodium steadily over 18 to 24 hours. The dosing interval for this new formulation should not be more frequent than once daily (q 24 h). Hypotension, sedation, heart block, or deep coma may occur if DEPAKOTE **ER®** is confused with DEPAKOTE® delayed release tablets, a formulation that is enteric coated, released over an 8 to 12 hour period, and can be taken more than once daily.

DEPAKOTE® (delayed release) is indicated for patients with mania associated with bipolar disorder or for certain forms of epilepsy. However, like DEPAKOTE **ER®** it is also indicated for migraine headaches. Confusion is quite possible because the brand names are so similar, both are available in a 500 mg tablet strength, and the terms Delayed release and Extended release are not sufficient to adequately differentiate the products. The two formulations are NOT substitutable. Although both divalproex sodium formulations are sustained release, only the DEPAKOTE **ER®** should be dosed once daily. Quite a few practitioners have reported the high potential for confusion between these two sustained release formulations, and ISMP has already received one report about an actual error where the patient received 1,500 mg of DEPAKOTE® (delayed release) instead of DEPAKOTE **ER®**. The patient developed significant hypotension and sedation about 9 hours later as the full dose was released more rapidly than with the extended release formulation. Fortunately, this patient experienced no further adverse effects and no additional treatment was necessary.

SAFE PRACTICE RECOMMENDATIONS:

1) Educate patients, providers, and pharmacy staff about the different dosing schedules and indications for both formulations of divalproex sodium. 2) If possible, initiate a computerized alert to remind staff about the potential for mix-ups. 3) Design computer mnemonics to decrease the likelihood that the drugs will appear on the computer screen simultaneously. 4) Also, be wary of verbal orders since “ER” could sound like "DR" (delayed release) which some have used unofficially to designate the delayed release product. When repeating back the order to the prescriber, the clinician should always use the full words "Extended release" or "Delayed release", not abbreviations. The letters EC, used by some to describe the enteric-coated product, could also be confused with ER. 5) When either drug is prescribed, determine its indication for use. DEPAKOTE **ER®** is indicated solely for the prophylaxis of migraine headaches. Unlike DEPAKOTE® (delayed release), DEPAKOTE **ER®** has not been evaluated in the treatment of mania or epilepsy. 6) Separate the storage of the drug containers and use auxiliary warning labels to differentiate the products. 7) In hospital settings, avoid having both forms available, if possible. Ideally, someone will devise a standard way of designating various sustained release forms of drugs to minimize confusion and reduce the possibility of dispensing errors.

Editor's Note

Need ideas for your MTF pharmacy newsletter? The PEC encourages MTFs to forward the e-newsletter directly to all providers and/or to incorporate pertinent articles into e-mail alerts, local newsletters, website postings, or other means of communication. (Articles reprinted by permission from other sources are noted; please secure appropriate consent.) The PEC Update is also formatted as a MS Word file and an Adobe Acrobat (pdf) file to facilitate printing and copying—just see the links at the top left hand corner of any page.

Do you have an article you'd like to see published in the PEC Update? Contact the editor at **shana.trice@amedd.army.mil,** or call: DSN 421-9551, Commercial (210) 295-9551

Would you like to receive the e-mail newsletter direct to your Inbox? Let us know by e-mailing Carol Scott, the PEC secretary, at **carol.scott@amedd.army.mil** or call: DSN 421-1271, Commercial (210) 295-1271. We can also send the Word version of the Update as an attachment for those who have trouble accessing the website.

Give us feedback! We'd love to hear from you! Contact the editor at **shana.trice@amedd.army.mil** or call: DSN 421-9551, Commercial (210) 295-9551. Contact numbers and e-mail addresses for other PEC staff members are available on the PEC website (**www.pec.ha.osd.mil**).